

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

8743
Do not use this space.

1. PLACE OF DEATH

(a) County..... / Registration District No. 10013
(b) Township..... Primary Registration District No. 10013
(c) City ST LOUIS (d) Street No. BETHESDA HOSPITAL St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Curtis Melvin Snyder
(a) Residence, No. 3649 Vista Ave. St. Louis, Mo. St. WA Batchtown, Illinois
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) January 30, 1940
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
0 1 4

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Infant
9. Industry or business in which work was done, as saw mill, bank, etc. Infant
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Batchtown, Illinois (STATE OR COUNTRY)

13. NAME Cyril Snyder
14. BIRTHPLACE (CITY OR TOWN) Illinois (STATE OR COUNTRY)

15. MAIDEN NAME Clarissa Grigsby
16. BIRTHPLACE (CITY OR TOWN) Illinois (STATE OR COUNTRY)

17. INFORMANT Parents (ADDRESS) Batchtown, Illinois

18. BURIAL, CREMATION, OR REMOVAL PLACE BATCHTOWN ILL. DATE 3-6-40

19. FUNERAL DIRECTOR ALBERT H. HOPE (ADDRESS) 11200 WASHINGTON AVE.

20. FILE MAR 5 1940 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 4, 1940

22. HEREBY CERTIFY That I attended deceased from February 23, 1940, to March 4, 1940

I last saw him alive on March 4, 1940. Death is said to have occurred on the date stated above, at 9:50 P.M.

The principal cause of death and related causes of importance were as follows:

Marasmus

Date of onset 2/10/40

Other contributory causes of importance:

Gastro-enteritis

2/18/40

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Engene Pitts II, M.D., M. D.

(Address) 3649 Vista Avenue

STATEMENT BY LICENSED EMBALMER

I, W. E. Embalmer, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

_____, L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)